FINANCIAL ARRANGEMENT PLAN

Patient Name _____ Account Number _____

Fee for Services	$
First Payment	$
Upload Balance	$
Amount Remaining	$
Total Payment Due	$

I have reviewed the charges for services rendered. Beginning with the first installment on _____ , I agree to make monthly payments of $_____ , which are due on the ____ day of each consecutive month to be paid to _____ until the balance of $_____ is paid.

Late Fee

I understand that I am responsible for all charges from _____ for treating my dependents or me. I understand that my account will be considered delinquent if my payment is more than 5 days later than I promised. If I make a payment late, I will be sent to collections. I understand that I will be legally responsible for all collection costs if I default on this agreement. I understand that I have a right to request and receive and itemization of the amount I am financing.

☐ I request an itemization today.

☐ I do **not** request an itemization today.

I have read the above description of the financial arrangement and agree to what it says.

Patient Signature _____ Date _____

Witness Signature _____ Date _____